

## Northern Valley Obstetrics & Gynecology, P.C. REGISTRATION FORM

Today's date:				PCP:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
<b>E-mail address for Correspondence:</b>		(Former name):			Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Social Security no.:			Home phone: ( )		Work Phone: ( )		
Street address:				Cell Phone: ( )			
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ( )		
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.			
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:							

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date:	Address (if different):			Home phone no.:	
		/ /				( )	
Is this person a patient here?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:		Employer:	Employer address:			Employer phone no.:	
						( )	
Is this patient covered by insurance?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate <b>primary</b> insurance		<input type="checkbox"/>					
		<input type="checkbox"/> Other					
Subscriber's name:		Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:	
			/ /			\$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of <b>secondary</b> insurance (if applicable):		Subscriber's name:			Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.:
			( )
			( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Northern Valley OBGYN or insurance company to release any information required to process my claims.			
I authorize my provider to contact me via _____			Date _____
Patient/Guardian signature			Date _____



**GYNECOLOGY HEALTH HISTORY**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ APPOINTMENT DATE: \_\_\_\_\_

**REASON FOR TODAY'S VISIT:**

**GYNECOLOGY HISTORY:**

LAST PAP TEST: HAVE YOU EVER HAD AN ABNORMAL PAP? \_\_\_\_\_

LAST MAMMOGRAM: HAVE YOU HAD AN ABNORMAL MAMMOGRAM? \_\_\_\_\_

URINARY INCONTINANCE PROBLEMS

**OB HISTORY:** # PREGNANCIES \_\_\_\_ # BIRTHS \_\_\_\_ DID YOU HAVE PROBLEMS WITH PREGNANCY?

**MEDICAL HISTORY:**

PAST MEDICAL PROBLEMS:

PAST SURGERIES:

HOSPITALIZATIONS:

**ALLERGIES:**

**CURRENT MEDICATIONS (Include OTC vitamins, herbal supplements & pain relievers)**

**BIRTH CONTROL METHOD:**

**HORMONE THERAPY USE:**

**MENSTRUAL HISTORY:** LAST PERIOD \_\_\_\_\_ ARE YOU HAVING PROBLEMS WITH PERIODS?

**SOCIAL HISTORY:** S \_\_ M \_\_ W \_\_ D \_\_ \_\_\_\_\_ LENGTH OF CURRENT RELATIONSHIP \_\_\_\_\_

DO YOU HAVE ANY CONCERNS OF SAFETY OR ABUSE?

WORK @ \_\_\_\_\_ ATTEND SCHOOL @ \_\_\_\_\_

DO YOU SMOKE? \_\_\_\_\_ DRINK ALCOHOL? \_\_\_\_\_ USE DRUGS? \_\_\_\_\_

**FAMILY HISTORY (Parents, grandparents, siblings, children):**

HIGH BLOOD PRESSURE \_\_\_\_\_ HIGH CHOLESTEROL \_\_\_\_\_

HEART ATTACK/STROKE \_\_\_\_\_ DIABETES \_\_\_\_\_

THYROID \_\_\_\_\_ OSTEOPOROSIS \_\_\_\_\_

BREAST/OVARIAN CANCER \_\_\_\_\_ COLON CANCER \_\_\_\_\_

MENTAL ILLNESS \_\_\_\_\_ OTHER \_\_\_\_\_

**WELLNESS SURVEY: DO YOU**

EAT HEALTHY? \_\_\_\_\_ GET 3-4 SERVINGS OF CALCIUM? \_\_\_\_\_  
 DRINK CAFFEINE \_\_\_\_\_  
 EXERCISE? \_\_\_\_\_ # OF TIMES/WEEK \_\_\_\_\_  
 USE SEATBELTS? \_\_\_\_\_ USE SUNSCREEN? \_\_\_\_\_  
 DO BREAST EXAMS? \_\_\_\_\_  
 HAVE QUESTIONS ABOUT HEALTH SCREENINGS OR TESTINGS?

ARE YOUR IMMUNIZATIONS UP TO DATE?  
 TETANUS (EVERY 10 YEARS) \_\_\_\_\_ HEPATITIS B SERIES \_\_\_\_\_ FLU SHOT (YEARLY) \_\_\_\_\_  
 PNEUMOCOCCAL \_\_\_\_\_ HPV VACCINE SERIES \_\_\_\_\_

**REVIEW OF SYSTEMS: ARE YOU CURRENTLY HAVING PROBLEMS WITH:**

HEADACHE, EYE, EAR NOSE OR THROAT PROBLEMS \_\_\_\_\_  
 BREASTS (LUMPS, NIPPLE DISCHARGE, PAIN) \_\_\_\_\_  
 ABDOMEN (PAIN, BLOATING, CONSTIPATION, DIARRHEA) \_\_\_\_\_  
 URINARY TRACT (BURNING, DRIBBLING, BLOOD IN URINE) \_\_\_\_\_  
 VULVA (SORES, DRY SKIN, PAIN WITH SEX) \_\_\_\_\_  
 VAGINA (DISCHARGE, ODOR, PAIN WITH SEX) \_\_\_\_\_  
 PELVIC PAIN \_\_\_\_\_  
 CONCERNS OF STD RISKS IN RELATIONSHIP \_\_\_\_\_  
 PMS SYMPTOMS \_\_\_\_\_  
 MENOPAUSAL SYMPTOMS \_\_\_\_\_  
 PROBLEMS WITH BIRTH CONTROL OR HORMONES \_\_\_\_\_  
 CHANGES IN SKIN OR MOLES \_\_\_\_\_  
 DEPRESSION SYMPTOMS \_\_\_\_\_

<b>DATE REVIEWED</b>					
<b>STAFF INITIALS</b>					
<b>PATIENT INITIALS</b>					

Revised 4/08

**COMMENTS:**

**AUTHORIZATION FOR RELEASE OF INFORMATION/ASSIGNMENT OF  
BENEFITS**

**Life Time Authorization**

If you have healthcare insurance or are entitled to benefits under any private or governmental health plan or policy, you agree that Northern Valley Obstetrics & Gynecology may bill these payers and they will make their payments directly to Northern Valley Obstetrics & Gynecology.

Your signature authorizes Northern Valley Obstetrics & Gynecology to release required medical information to your insurance company/third party payer for the completion of your claim.

\_\_\_\_\_  
Patient or Authorized Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date



## NOTICE OF PRIVACY POLICY

March 31, 2006

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

### Why Do We Publish This Notice?

As health care professionals, we understand that information about you and your health is sensitive and personal. We are also required by law to maintain the privacy of information that we gather and use about you, and all of the patients we serve. We also will provide you with notices of our legal duties and privacy practices with respect to your information.

We are committed to the privacy of our patient's information. However, in order to serve you, we need to obtain, secure, and utilize your records. We occasionally need to share health information with other healthcare, insurance, and billing providers.

This notice is also to inform you about certain legal rights you have with respect to the information we secure. You have the right to review and copy information in your records. You may also request that we amend these records, and may ask us to account for certain disclosures.

### INDIVIDUAL RIGHTS REGARDING PROTECTED HEALTH INFORMATION – PHI

You have certain rights under federal privacy standards including:

- The right to receive a printed copy of this notice
- The right to inspect and receive copies of your PHI – Northern Valley Obstetrics & Gynecology may charge a reasonable fee for copying, postage, labor and supplies
- The right to amend or submit corrections to your PHI
- The right to request restrictions on the use and disclosure of your PHI – we are not required to agree to your request
- The right to receive and specify confidential communications concerning your PHI and treatment
- The right to receive an accounting of certain disclosure of your PHI except for disclosures made for treatment, payment, health care operations or with your written authorization

### USES OF DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION – PHI

**TREATMENT:** your PHI may be used by Northern Valley Obstetrics & Gynecology clinic staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, providing treatment, and managing your health care and related services.

**PAYMENT:** your PHI may be used by Northern Valley Obstetrics & Gynecology to bill and collect payment for treatment and services and to seek payment from your health plan, such as Medicare/Medicaid/Blue Shield of ND or MN and other third party payers.

**HEALTHCARE OPERATIONS:** your PHI may be used by Northern Valley Obstetrics & Gynecology and disclosed to other agencies to improve quality of care, reduce healthcare costs, provide training programs for students, healthcare providers, and non-healthcare professionals or for business planning, management, and development.

**COMMUNICATION:** your PHI may be used by Northern Valley Obstetrics & Gynecology to send you appointment reminders or other information about treatment options or health related benefits via encrypted e-mail or US Postal Service.

**GOVERNMENT AGENCIES:** your PHI may be disclosed by Northern Valley Obstetrics & Gynecology to Public Health Agencies, Coroner, Medical Examiner, Funeral Director, Government Agencies, or Law Enforcement Agencies as required by law to support government audits and inspections, to facilitate law enforcement investigations, to comply with government mandated reporting, or in the case of suspected domestic violence, abuse or neglect.



## **Our Financial Policy**

*We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.*

- 1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept Visa and MasterCard.**
- 2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor- in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.**
- 3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment at the time of your visit.**
- 4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.**
- 5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be “not covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.**
- 6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.**

**I have read and understand the practice’s financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.**

---

**Signature of patient (or responsible party, if minor)**

**Date**

---

**Please print the name of the patient**